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St. Bartholomew's Hospital Journal,

SEPTEMBER 14th, 1895.

"Æquam memento rebus in arduis
Servare mentem."—*Horace,* Book ii, Ode iii.

Introductory Remarks to the First Lecture on the Principles and Practice of Physic, October 2, 1894.

By SIR DYCE DUCKWORTH, M.D., LL.D.

GENTLEMEN,—We meet to-day to begin our winter course of lectures on the Principles and Practice of Physic. Some of you will remember that my colleague, Dr. Norman Moore, opened this course last October with a very noteworthy and learned prelection, and explained the scope and aims of our duties in this theatre.

I am tempted now to offer a few remarks on the subject of lectures on General Medicine in relation to modern methods of studying medicine, for it is known to every one that great changes have come about in the last fifteen or twenty years in the curriculum of students. When I was *in statu pupillari* in Edinburgh the system was practically entirely professorial. We were lectured from morning till evening, and attended about five lectures daily. Tutorial teaching was little available, and quite subordinated to the systematic lectures. To-day we find that students have fewer lectures and more practical instruction, less professional and more tutorial work to avail themselves of. In the main I believe this change to be for good. In London the student has large practical opportunities, and, as a rule, passes out of his school better equipped for practice than do students from some large schools elsewhere. He is more practical and less theoretical.

The modern tendency, then, is somewhat to decry systematic lectures, and to urge diligent attendance upon tutorial classes, and it is stated as one reason for this practice that systematic lectures are the less necessary in these days as the student has access to excellent text-books, which fully embody the best teaching and knowledge extant. This is partly true, but not quite true. We meet the requirements of to-day in this and, I think, in all the London schools by a middle course, and we do well. We adopt the recommendation of the General Medical Council in this matter, and give you three systematic lectures in the weeks of the winter session, while we commit you to the admirable instruction, ancillary to these lectures, given by such capable teachers as Dr. West, Dr. Calvert, and Dr. Andrewes. With five teachers of medicine in this school, I think we do justice to this great subject. We do not forget that for the great majority of you your subsequent life-practice will be far more medical than surgical; and for those of you who may elect to practise wholly as surgeons, I need hardly tell you that a good knowledge of medicine is, in these days, more than ever necessary, since surgeons now largely take part in the conduct of cases that come primarily under medical care. I must complement this statement at once, however, by stating that a physician who is little conversant with modern surgery, nowadays can be but a very imperfect medical adviser.

In endeavouring, then, to teach you medicine here you will observe that I claim nothing very special for it. We have regard to all your needs as students of your whole profession, for neither we nor you dare to specialise in any

direction. We hear far too much in these days of specialisation in medicine. It is the plague and the cant of the day, bad, as I have elsewhere said, for all of us, and very bad for the public who have seized the idea of it and try to degrade us down to such a level. But we will have none of it. We have no "specialists" on the staff of St. Bartholomew's Hospital. Some of us are attached to special departments, and of course we recognise such specialties as ophthalmology and gynæcology, but we remain, and we intend to remain, for the best interests and renown of our school, with the two exceptions I have named, *general* physicians and *general* surgeons.

In your education here we recognise a place for systematic teaching in medicine and surgery in their widest aspects, and we bid you to be wise enough to avail yourselves of instruction in this form. What is this instruction? It is not a perfunctory dull mumbling of dry written lectures, of such as are unfailingly soporific and inevitably wearisome. At least I trust not. It is rather, or it certainly should be, a clear and lucid exposition of principles, with the fullest illustrations from bedside experience of disease in all its recognised forms; an instruction living, fervid, and delivered with an enthusiasm only chastened by daily renewed lessons fresh from the efforts (*i. e.* the successes and the failures) of daily practice of our art. Gentlemen, you will not find this in any modern text-book with which I am acquainted. The best of these too often are founded on purely hospital experiences, and these, though of very great value, do not meet all your needs as practitioners of the future. A large part of your after-life work will be very different from hospital practice. You need guides to the work that will await you in very different environments, and we as your teachers here can help you to learn something in preparation for that. We can tell you of disease in less grave phases and in less well-expressed forms that you hardly meet with here, and we can tell you more of the after-history of cases than it is possible for you to learn either in the wards or from any text-books.

Believe me, you will do well to attend diligently all the systematic lectures provided here. You will almost unconsciously acquire stores of knowledge and experience which will years hence come in to help you and lighten your difficulties when you have no one to lean upon or take counsel with. By means of these lectures you will better understand both your work in the wards and your reading in text-books. You need all; all are necessary, and you cannot afford to leave out any one method of instruction.

If you assume in the jargon of the day that you may safely dispense with systematic lectures, you do violence to the memory of some of the greatest men who have graced our profession. You cannot suppose that men like Graves, Watson, Todd, Bright, Gull, Jenner, Burrows, Andrew Clark, Andrew, and many others were foolish enough to give systematic lectures for the best years of their fruitful lives if they believed them to be of little or no use. We have fewer lectures, as I have said, now than when these men taught, and we have added many new methods of teaching in recent times; true, but I am not sure that we have more, if we have as many, giants in medicine as when these men were actively engaged in teaching.

Let us beware of breaking in rudely upon the old order of things. I am no Tory in physic, but I am certainly no Radical. We are not to go blindly with the times, but to go forward prudently, accepting light, help, and knowledge from all sources as we go. But if we begin by believing that our forefathers in the profession were all fools, we shall very soon suffer for our conceit. Rather we will go wisely and well.

This course, as some of you know, occupies two winter sessions for its completion. Formerly one session sufficed. Everything in medicine has grown, and happily your curriculum has been extended to keep pace with this growth. I trust that you are now preparing to make the use designed for it of the fifth year now required from you. In that final year you are set free from lectures, and expected to be acquiring the practical art of your profession by diligent work in the wards, out-patient, and post-mortem rooms. As you sow now in this seed-time, so will you certainly reap in your fifth year and subsequent career. Put off nothing now till that later day which never comes to the procrastinator. All that comes to him is a day wherein to repent at leisure of his idleness and ease-taking. You may fairly trust us, your teachers, in this matter. We have your best interests at heart, and we wish you so to study here that you may never regret the efforts you made with us. And your work is indeed hard. We know it well. You need much courage and great perseverance. Be assured these will not fail to bring you your full reward in due time. In order to work well, you must play well. We enjoin that, and we have lately done something to enable you to do it. Whatever may be the case in other professions, medical men must be before all else robust men, robust in body as in mind. If you neglect your muscles you will have unstable brains. Everything, then, in its place, and moderation in all. Add to these what I will call staying power, hold on, peg away, and do not look back.

I am tempted to say something respecting the most recent advances in our knowledge of practical medicine. These are now running very much on one line, the line of bacteriological research. There is always something uppermost and to the front, and just now the most actively pursued topics relate to microbes. In my student days microscopic morbid anatomy was the rage, and the fight was carried on over cells, molecules, corpuscles, and all the elements in every solid and fluid of the body. The true features of a tubercle-corpuscle, or the nature of a leucocyte, were then being debated amidst war and some recrimination. Just now we look on at the strife engen-

dered by disputants over the size, the wrigglings, and wondrous ways of the *Bacillus coli* and that of the enteric fever poison. My colleague, Dr. Klein, is very confident that he has now tracked that last plague-producer to earth. So with the specific elements giving rise to that still worse pest—diphtheria. We appear to have recognised its microbe, and to be thus empowered to establish, more often than we now do, a diagnosis in cases of sore throat of uncertain nature. Inquiries such as these are pregnant with interest, but above all are of vast importance for us and for all mankind.

Not only in exact researches such as I have mentioned, but in the fact that in the daily study of disease we meet with endless varieties of symptoms of processes, never twice quite the same, we have in the study of medicine an undying source of interest, so that we, with you, are always students, ever reaching on to the far-off goal of eternal truth. Do not suppose that you can ever, here or anywhere else, come to know any disease as an entity or a condition. There is verily no such thing.

You learn to make a diagnosis, say of a case of pneumonia; you know its history, symptoms, signs, and prognosis. You think you know how to treat such a case perhaps. Perhaps in the very first one you meet with, you find all your conceptions at fault, the symptoms and signs not "classical," and you are perplexed as to the issue. What does this indicate? It means that no two cases of disease are alike, and that they never can be alike. What have you to do? You have to study *patients*, that is, sick people who are suffering day by day and night by night; and you have to discover what disease means to each individual afflicted with it. In that way only can you fit yourselves to treat the *patient*. Remember that only homœopaths and charlatans treat *diseases*. You will not find us treating diseases here. We are busy with *patients*, discovering the personal needs and tendencies of each, and so engaged in helping them to recover and become sound in health once more. How can a text-book help you in such a work as this? It never yet helped any one to become what I term an artist in medicine, and all our work in this theatre, and in our wards, with you is to enable you to become for yourselves good *medical artists*. Every great physician or surgeon is a great artist. Many will refuse to us any claim to be scientists. Let them refuse it. It matters not at all. Our business is to heal the sick and to relieve suffering, and if we can do that we may be content to be called by any name. Our art, however, is founded on many sciences, and we can acquire no true art before we are grounded in all the sciences on which it depends. You lay this solid foundation in your preliminary and systematic studies here, and you rear the artistic superstructure in your fifth year, and in every subsequent year of your medical life.

Let me urge you not to be discouraged by many apparent failures in such work as we carry on here. We have our failures and disappointments as all good men must have in this world, but we learn daily from our mistakes if we are honest, and others, in turn, reap wisdom from them. What we have each to do is to do nothing less than our best, to do everything with our might, and to fear no man.

Gentlemen, with these somewhat desultory and introductory remarks, I now pass on to my first lecture in this winter's course, and begin to study with you the subject of Hydrophobia.

Osteophytic Outgrowths removed from the Articular Surfaces of both Knee-joints, with Restoration of the Normal Joint Movements.

By W. BRUCE CLARKE, F.R.C.S.,
Assistant Surgeon to the Hospital.

HISTORY.—R. M—, aged 35, was admitted into St. Bartholomew's Hospital on September 22nd, 1891, in consequence of some pain and discomfort in connection with the movements of her right knee-joint. She stated that for some months past she had been liable to sudden attacks of pain when executing rapid movements with her knee; they came on, for instance, when she started up out of a chair, or changed her position from kneeling to standing, or occasionally on getting out of bed in the morning. Recently the pain had become much intensified, and had on several occasions caused her to fall. The pain subsequent upon these attacks had lasted longer than it used to, and sometimes for several weeks, off and on, she would suffer from aching in the region of the knee, which was aggravated by movement, and latterly had prevented her from taking any considerable amount of exercise at all. She could not walk more than a mile or two at the outside, and often not nearly as far; her walking powers varied a good deal from time to time.

After she had been in bed a few days, and the synovial membrane, which on admission had been distended with an excess of fluid, had almost recovered its normal shape and dimensions, a careful examination of the knee-joint was undertaken.

There was a spot tender to pressure on the outer side of the patella, and underneath it there appeared to be some thickening of the subjacent tissues, probably implicating the synovial membrane, and possibly also the articular edge of the femur. No distinct loose body could be felt, but a day or two later she drew my attention to something which undoubtedly moved about in this region to a limited extent.

Her general health was good, and until her recent pains in connection with the right knee-joint she had never suffered from anything which had laid her up. She had never had an attack of rheumatism.

October 2nd, 1891.—The patient was taken into the theatre, and an incision made on the outer side of the patella over the spot where the pain was most obvious. On opening the knee-joint the articular edge of the femur was seen to be lipped and thickened, and on the edge of the synovial membrane was found a thickened fringe containing a potential loose body. The pedicle by which this potential loose body was attached to the remainder of the synovial membrane was ligatured with fine silk and then severed. The thickened edge of the articular surface of the femur was removed with a gouge, all bleeding arrested, and the wound closed with silk sutures.

The patient made an uninterrupted recovery and left the hospital on October 15th, able to walk with a stick. A few months later she came to see me, saying she was perfectly well and able to walk any distance.

I saw no more of her until she again came under my care on January 9th, 1895. Her right knee had never given her a moment's anxiety since I had last seen her, but about two years ago, viz. in 1893, she noticed what she described as some slipping of the left knee-cap. This caused her to slip down, and produced a locking of the knee-joint, and until she could manipulate the joint she could not get up again. Latterly these attacks had occurred as often sometimes as twice a day, but from constant practice she had become quite an adept at restoring the parts to their proper situation. The knee-joint usually became swollen for some hours after each attack, after which the swelling and discomfort disappeared. She had tried knee-caps, iodine, and blistering, but without any permanent relief.

No fault was to be found with her general health; there was a slight extra amount of fluid in the left knee-joint, and some thickening of the synovial membrane. No outward displacement such as she described could be discovered.

On the internal edge of the condyle of the femur a tender osteophytic growth could be distinctly felt, and a second one just below it. There was marked creaking when the joint moved. The movements of all her other joints were natural and normal in extent and direction. Close by the old incision on the outer side of the right patella could be felt a thickening, apparently of the outer edge of the patella, but it evidently gave rise to no pain or inconvenience whatsoever.

January 21st, 1895.—An incision two and a half inches long was made along the inner border of the left patella, and after all bleeding had been arrested the capsule of the joint was opened. No free loose bodies were felt, but a hard, sharp-edged osteophyte came into view along the inner border of the femoral condyle. This was removed with a gouge, and a roughened patch on the opposing surface of the patella was also scraped. Two or three large pedunculated fringes were at the same time removed from the synovial membrane, after which the edges of the wound were carefully sutured and the knee placed on a back splint.

An uninterrupted recovery took place as on the previous occasion, but the restoration of complete and easy movement was more prolonged than it had been in the case of the right knee. In March of the present year the patient came to see me in the out-patient room, and expressed herself as feeling perfectly well and active.

Remarks.—The history of this patient's case appears worthy of record from several points of view. In the first place there is a clear evidence of the presence of rheumatoid arthritis in both knee-joints, which so far interfered with their normal movements as to necessitate operative interference, and in each case has resulted in perfect restoration of function. In neither case was a true loose body found. The edges of the synovial membrane were thickened, and had they remained for some long time without operative interference probably would have become detached, and have given rise to true loose bodies. It is worthy of note that the symptoms were almost exactly the same as if actual loose bodies had been present. Much of the benefit derived from the operations was doubtless attributable to the removal of the osteophytic outgrowths from the edges of the opposing surfaces of the articular ends of the bones, a result which should encourage one to advise removal of such outgrowths even when no loose bodies are present. What length of time may elapse before such growths again begin to interfere with joint movement it is of course impossible to state, but it is very encouraging to note that in the case of the joint first operated on no such interference after a lapse of nearly five years has yet begun to manifest itself.

Notes on Aseptic Surgery.

By C. B. LOCKWOOD, F.R.C.S.,
Assistant Surgeon to the Hospital.

(*Continued from page* 166.)

KOCH'S* experiments showed that the vapour of oil of turpentine failed to affect earth spores in sixty days, and ten days' exposure of anthrax spores to water containing a few drops of oil of turpentine, with frequent shaking, gave a similar negative result. The pure oil killed anthrax spores in five days, but failed to do so in one day. The development of anthrax spores is prevented by 1 in 75,000.

As a rule, I find that house surgeons prefer to use ether. The methylated kind is quite good enough for the purpose. The sisters and nurses praise turpentine for cleansing the feet or hands or knees of labouring people. Ether or turpentine may be rubbed in with a swab of absorbent cotton wool.

The bacteria which inhabit the ducts of the sweat-glands and mouths of the hair-follicles are either removed by these

* *On Disinfection*, p. 510.

measures, or the disinfectants are enabled to reach their hiding-places. These measures likewise get rid of or lay bare to disinfection the bacteria which inhabit the ducts of the sweat-glands and the mouths of the hair-follicles.

After the skin has been shaved, cleansed, and its sebaceous matter extracted, it is disinfected with chemicals. After what has been said it is obvious that dilute solutions would have no effect. We therefore soak the prepared skin for two minutes with the same solution of spirit and biniodide of mercury as that which was used to disinfect the hands. This consists of 1 part of biniodide dissolved with the help of iodide of potassium and water in 500 parts of rectified spirit. Before use a tenth part of hot water is added to render the action of the drug more certain. This spirituous solution spreads evenly upon the skin, and seems usually to penetrate its depths. In the last series of cases treated in this way eleven out of twenty-one were aseptic. Some of this skin was from regions which are the hardest to deal with. As we gain experience and learn how difficult it is, and what strenuous exertions it requires to disinfect the skin our results improve. It is clear, however, that we are far from having learnt the best way of disinfecting the skin. But the nature of the problem is such that more will always depend upon the care with which the skin is prepared for disinfection than upon the kind of disinfectant which is applied. After the skin has been disinfected it has to be kept aseptic until the operation. For this purpose we place next to the skin a layer of 5 per cent. carbolic gauze which has been soaked in biniodide of mercury lotion for at least twelve hours. This lotion contains 1 part of biniodide in 2000 parts of water. It is advantageous to use glycerine instead of water, but as solutions of disinfectants in pure glycerine are inert, the whole of the water ought not to be replaced with glycerine. Dr. Black Jones and Mr. Furnivall grew bacteria from threads which had soaked for ten minutes in fresh glycerine and carbolic acid, one part in twenty. Glycerine in biniodide, 1 in 2000, and glycerine in perchloride, 1 in 1000, did not disinfect in one minute. The addition of glycerine keeps the gauze continually moist, and also helps the disinfectant to soak into the skin. This layer of wet gauze is covered with a layer of blue wool, and an outside dressing bandaged over the whole. The dressing should fit accurately, and may be used again after the operation. It consists of eight layers of 5 per cent. carbolic gauze covered with a layer of waterproof jaconet. Its construction and uses will be described when I come to the final dressing of the wound. When there is a septic ulcer or sinus in the skin which has to be prepared for operation the process of disinfection is much more difficult and uncertain. Not only should an attempt be made to disinfect such as these before the operation, but after the patient is anæsthetised they ought to be thoroughly scraped with a sharp spoon, soaked with pure carbolic acid, or touched with the actual cautery, irrigated with 1 in 1000 biniodide of mercury lotion, and shut off as far as possible from the field of operation by packing them with carbolic gauze. Sometimes a layer of gauze soaked in iodoform collodion seals the infected region, and affords a fair protection. The only case I have lost from septicæmia was infected from a cancerous ulcer which had not been properly disinfected. I was not then aware of the impotence of our chemicals.*

The preparation of the instruments has been mentioned more than once. The following suffice for almost every operation, namely, a knife, a pair of scissors, a pair of dissecting forceps, six to twelve pairs of pressure forceps, a straight needle, and a curved needle. For special operations amputating knives, saws, bone forceps, blunt pointed needles on handles, and such like may be wanted in addition, but the foregoing are the stock ones. Every one of the instruments is put into boiling water for fifteen minutes, they are taken from the water without contamination, and arranged in a basin or tray filled with 2 or 2½ per cent. carbolic lotion.

If the operation is at a distance the instruments are boiled at home in a saucepan or small fish-kettle, and wrapped whilst hot in an ordinary outside dressing. This protects them from infection, and after the operation may be used for dressing the wound.

Frequent boiling certainly destroys the instruments. It does not seem to blunt the cutting instruments if they are protected from contact. Therefore the knife ought to be put in a rack or rolled in a thin layer of wool or muslin. Needles are best tied together with a bit of silk before being put into the boiling water.

The same instruments may be used for several operations, provided they have touched nothing septic. They merely require to be placed in fresh lotion. Of course the knife must be replaced if it has been blunted.

After the operation the instruments ought at once to be thoroughly cleansed of blood by an energetic scrubbing with soap and hot water. This makes their subsequent disinfection much more easy and safe.

It is unnecessary to say that the old-fashioned instruments with wooden or ivory handles are useless now. But instrument makers are gradually learning to make instruments with metal handles. For needles and retractors the bent wire handle, like that of a penny button-hook, is simple and very easy to hold.

All the other instruments which may be required for an operation are sterilised by heat, and kept aseptic with dilute chemicals. It would be wearisome to enter into further particulars.

The instruments are used with proper precautions. As I have said, the surgeon himself picks the instrument he requires from the tray of lotion, uses it, and puts it back in the tray. During its transit from the lotion to the wound

* Hunterian Lectures on "Traumatic Infection," *Lancet*, March 9th, 1895, vol. i, p. 296, *et seq.*

it touches nothing, or, at all events, nothing but things which have been sterilised and soaked in lotion. It is unnecessary to point out how irrational it is to disinfect instruments and then allow them to touch that which is infected.

Twisted silk is used for tying vessels, sewing together divided muscles or aponeuroses, or for securing pedicles. The smallest size is 00, and is suitable for the smallest vessels; but the larger sizes, 0, 1, 2, 3, 4, 5, and 6 are used according to circumstances. The quantity required for the operation is rolled upon a glass reel or glass microscopic slide, and is prepared by boiling for fifteen minutes to half an hour in water. The shortest boiling suffices for the thinnest kind, provided too much is not rolled upon the glass reel. After twice boiling the silk becomes brittle and unreliable, especially the thinnest kinds. After having been disinfected the silk is put in a bowl of 2 or 2½ per cent. carbolic lotion, from which it is taken by the surgeon. It should be handled as little as possible, and touch nothing unsterilised in its passage from the lotion to the wound; indeed, it is best if it touches nothing whatever. Silk which has to be transported is placed in a jar of 5 per cent. carbolic lotion. This strength allows a little for evaporation, but is rather too strong for the surgeon's hands. The silk, therefore, is taken from it at the operation and put in 2 or 2½ per cent. lotion.

Silkworm gut, or fishing gut, as it is also called, is used for skin sutures, and not infrequently for buried sutures too. It is quite unirritating, and, owing to its physical properties, has no capillarity. Thus when it is placed in the skin no fluids can pass along it either into or out of the wound. It is prepared by boiling and immersion in lotion the same as the twisted silk, and bears the treatment exceedingly well. One or two boilings seem to have no effect upon it, and soaking in lotion only makes it tougher and stronger. The thickness of the fishing gut ought to be proportionate to the strain it has to bear. For a laparotomy wound thick strains should be chosen, but thin ones do for ordinary skin wounds.

This mode of preparing silk and fishing gut is quite reliable. Nine specimens were tested during this year and last by dropping bits of them into broth. In every instance the result was aseptic.

For some wounds, such as circumcision, or wounds about the face, ordinary raw catgut is a valuable material, as it does not require to be taken out. Moreover some surgeons use it for the ligature of vessels. Catgut prepared after Esmarch's* directions is, I have found, quite sterile. His method is as follows. The ordinary commercial catgut, Nos. 1 to 3, is vigorously cleaned with a brush in soft soap and water, and after washing in pure water is wound on glass spools and laid in bichloride solution, 1 to 1000, for twelve hours; then in an alcoholic 1 to 200 solution of bichloride for twelve hours, and it is then preserved dry in tightly closed glass vessels. Just before it is used it is laid in a vessel filled with an alcoholic 1 to 2000 solution of bichloride.

In this process the scrubbing with soap and water is very important. Reverdin* has pointed out that as a last stage in its manufacture the catgut is oiled. If this grease were left it is unlikely that the disinfectants would penetrate. Soaking in ether may be used to help its removal, and the perchloride which Esmarch uses may be advantageously replaced with the same strength of biniodide of mercury.

Reverdin† sterilises raw catgut which has not been oiled by putting it in the dry-heat oven for four hours at 140° C.

Some wounds require a drainage-tube of glass or india rubber. These are disinfected by boiling in exactly the same way as the instruments. They are usually kept with the ligatures and sutures. I always drain wounds which pass through septic sores or sinuses. It is doubtful whether these wounds can be made aseptic by any of our present means. Harm ensues if septic fluids are allowed to collect within them. I also drain wounds in parts where pressure cannot be applied, and in which blood easily accumulates. Thus a drain is always put into scrotal wounds after radical cure of hydrocele or varicocele, or after castration. It is also wise to drain wounds in which there is oozing of blood. After amputation through the condyles of the femur, or after Syme's amputation, the cancellous tissue of the bones is very apt to ooze. The blood collects within the flaps, and not only causes pain, but also predisposes to suppuration should asepsis not have been achieved. As a rule the drain is taken out at the end of forty-eight hours. After amputation such an early dressing is exceedingly painful, and therefore the tube is left until the eighth or tenth day. By that time the wound is almost healed, so that all the sutures may be removed as well as the tube. A little iodoform emulsion is squirted into the opening left by the tube, and it speedily closes.

Towels are used to spread upon the tables which hold the bowls for instruments, ligatures, and sponges; and also for surrounding the field of operation, and for barring off any septic region like the scalp. Mere soaking in strong solutions of chemicals cannot be relied upon to sterilise these towels. Out of four towels which had been soaked for two hours in 1 in 20 carbolic lotion one was aseptic; the other three infected broth with *Staphylococcus pyogenes albus*, with cocci singly and in pairs, and in strings of seven or less, and with a white mould. Another towel, which had been kept in carbolic lotion 1 in 25 for twenty hours, grew a bacillus with a strong sebaceous odour. Towels are seldom soaked in perchloride of mercury because it discolours them. A towel which had been in 1 in 2000 sublimate for some time contained *Bacillus subtilis*, but another which was immersed for three hours was sterile.

* *The Surgeon's Handbook*, translated by Curtis, 1888, p. 15.

* *Antisepsie et Asepsie chirurgicales*, p. 121, *et seq.*

† Loc. cit., p. 128.

These difficulties are easily overcome by boiling or steaming the towels for half an hour. But it is important to open out the towels before they are boiled or steamed. We omitted this precaution when we first began this plan. Although the towel had been steamed for half an hour, and soaked in 1 to 20 carbolic lotion for more than half an hour, it grew staphylococci, cocci in chains of six, and a spore-bearing bacillus such as I have often seen in cultures inoculated with skin scraping. After what has been said it may be supposed that these escaped by being protected from the steam by the folds of the towel. When the towels are taken from the steriliser they are put into carbolic lotion, 1 in 40. The surgeon himself or his assistant takes them out of this, wrings out the excess of lotion, and uses them to surround the field of operation.* The last nine towels which were tested after having been prepared in this way were all sterile.

Of all the materials which I have had to use, or seen used, for clearing wounds of blood, none seems so satisfactory as a good sponge.

The main objection to sponges is that they are difficult to cleanse and disinfect, but the following method gives reliable results if properly carried out by a conscientious person. If the sponges be new, they are thoroughly shaken and beaten to get rid of the sand which is put into them to make them heavier. To remove the bits of coral and of shell they are soaked for twenty-four hours in a solution of hydrochloric acid and water. This is made by adding a drachm of strong acid to a pint of water. Next they are washed and squeezed out in warm water, temperature 100° F., which has been boiled and left to cool in a covered vessel to ensure its sterility; from this they are transferred for half an hour to a warm solution of ordinary washing soda (3j to Oj water) for the removal of any fat or albumen. Sponges full of blood, fat, and albumen may require several repetitions of this part of the process. The soda solution is removed by again rinsing in warm sterilised water, temperature 100° F., and the sponges immersed in cold solution of sulphurous acid (1 in 5) for twelve hours for a final bleaching and sterilisation. This solution is made by simply adding liquid sulphurous acid to water. During this stage a plate is placed over the sponges to sink them in the solution, otherwise they are apt to become discoloured. Lastly, they are squeezed as dry as possible, and placed in carbolic lotion (1 in 20) ready for the operation. Of course other lotions may be used for the purpose. During the operation the sponges are handed to the surgeon or his assistant in a bowl of lotion. The advantages of biniodide of mercury lotion for this purpose have been pointed out. Blood is so easily squeezed from the sponges when it is used, that it is seldom necessary for anyone but the surgeon or his assistant to touch them again. The lotion in which the sponges are handed not only ensures their sterility, but also helps to keep the hands of the surgeon and of his assistant aseptic. A sponge should be taken from the lotion, applied to the wound, and returned to the lotion. It is most dangerous and objectionable to lay sponges upon the body of the patient or upon the table, or even upon the sterilised towels. They are apt to fall upon the floor, or be brought in contact with things which have not been disinfected.

To save the troublesome preparation of sponges we use as few as possible. Six are enough for any operation, but for an abdominal section a flat sponge may be required as well. After sponges have been used with sublimate solutions, the preparation with sulphurous acid is apt to make them rather black and dingy. This is of no real consequence, and can be avoided by using strong chlorine water in place of the sulphurous acid solution. The chlorine is apt to make the sponges pink, and sometimes rather friable.

The chlorine solution is made by putting twenty grains of powdered chlorate of potash into a stoppered bottle, and adding to it two drachms of strong hydrochloric acid. The stopper is left out for ten minutes until all the air is expelled from the bottle. Then two pints of water are gradually added and the bottle well shaken. This solution has various names. It is called Mistura Chlori, Liquor Chlori, and Gargarisma Chlori. I am indebted to Mr. Parsons for these details.

Sulphurous acid is a disinfectant of some value. Sternberg found that micrococci were destroyed in two hours by 1 : 2000 by weight of SO_2 added to water. Kitasato found that solutions of sulphurous acid in the proportion of 0·28 per cent. killed the typhoid bacillus, and 0·148 per cent. the cholera spirillum. De la Croix found that one gramme of SO_2 added to two thousand of bouillon prevents the development of putrefactive bacteria, and after a time destroys the vitality of these bacteria. Sternberg found that pus cocci failed to grow in a culture solution containing 1 part of SO_2 in 5000 of water.*

Chlorine is an active germicide in the presence of moisture. Fischer and Proskauer found that moist anthrax spores exposed to a moist atmosphere containing 4 per cent. of chlorine, were killed in an hour. A moist atmosphere containing 1 part in 2500 killed anthrax bacilli and *Micrococcus tetragonus* in twenty-four hours, and the streptococcus of erysipelas in three hours.† I quote these observations because they show the potency of chlorine, and because of their bearing upon the disinfection of rooms. Koch found that anthrax spores did not grow after twenty-four hours in chlorine water. According to De la Croix, no bacteria developed in unboiled beef infusion when chlorine was present in the proportion of 1 : 15,000. Miquel also gives chlorine a high antiseptic value.

* "Report upon Aseptic and Septic Surgical Cases, with special reference to the Disinfection of Skin, Sponges, and Towels," C. B. Lockwood, *Brit. Med. Journ.*, Jan. 27th, 1894.

* The above is quoted from Sternberg's *Bacteriology*, p. 172.

† Sternberg, p. 169.

The methods which I have just described for the disinfection of sponges is reliable. Out of twelve which were tested by cutting off a scrap and putting it into broth, eleven were sterile. The one which was septic grew *Staphylococcus pyogenes albus*. The nurse who handed it was inexperienced. In a second series of thirteen one was septic. It contained a bacillus with peculiar characters, and different from any I have seen before.

The bowls used for instruments and sponges are disinfected by heat, otherwise they are a great danger. The usual wiping with carbolic lotion is quite untrustworthy. Dried pus or septic fluids would not be disinfected by such a proceeding. Therefore the bowls should be steamed or boiled for at least fifteen minutes. If this cannot be done, Forgue recommends that in country practice they be flamed with a little alcohol.* Very few bowls are required. The surgeon has one for his instruments, one for needles and ligatures, and one for the lotion in which he rinses his hands.

The nurse requires one bowl in which the sponges are given to the assistant. These sponges are handed in the lotion, from which the assistant squeezes them dry before sponging the wound. As a rule, the assistant himself cleanses the soiled sponges by squeezing them out in lotion. The nurse has merely to hand a fresh bowl of lotion. This can be kept ready mixed in a large jug or in another bowl. The apparatus of the anæsthetist must not be washed in the sterilised bowls used for the operation. Also the nurse must on no account touch his sponges or lint. It is better that he should defer his cleansings until the wound is safely covered with the dressings. Accomplished anæsthetists are on the alert to guard against infection from anything they have used.

It is needless to say that if an irrigator is used it ought to have been sterilised. For most operations, particularly those done upon the abdomen, I find an ordinary earthenware jug the simplest and best irrigator.

When these preparations have been made the patient is anæsthetised, taken to the operation room, and put upon a convenient table. This table should be wide and long enough to hold the patient, and should stand by itself in the centre of the room. The space around it should not be encumbered with spectators. Ample room must be kept for the surgeon's table of instruments, and for the nurse and her appliances. She ought to be allowed to pass whatever the surgeon or his assistant needs without any danger of touching the onlookers.

Anæsthetists who know the principles of aseptic surgery are careful to keep their lint or apparatus out of the field of operation. In operations about the head and neck this is not at all easy to manage. But, as a rule, the mouth and nose can be put in such a position as to avoid danger of infection from them. Moreover a barrier of disinfected towels can usually be raised betwixt the wound and the anæsthetist. I have tried various kinds of barriers and screens. None are of use without the help of a trained and zealous anæsthetist who stands out of the way behind the patient's head.

For most operations the surgeon stands upon the right-hand side of the table, the assistant on the left, and the nurse behind the assistant. The surgeon's instruments are put upon a table, so that he can pick them up without stepping from the position chosen at the beginning.

The patient having been anæsthetised is arranged upon the table in a convenient attitude. This is chosen with care, because it is dangerous to upset the field of operation in the midst of an operation by moving an ill-adjusted patient.

To prepare the field of operation the superfluous garments or blankets are taken away, but all unnecessary exposure is guarded against. The loss of heat is very great when a large area of skin is exposed to the air and wetted with lotions. The patient's body should be clothed in warm flannel garments, and the feet in stockings. When the patient is old or debilitated we wrap as much as possible of the trunk and limbs in layers of cotton wool. Shock can also be lessened by using hot appliances, by placing the patient upon a hot-water table or hot-water mattress, by stimulants before, during, and after the operation, and by cultivating that speed in operating which modern surgery demands. Therefore the area of operation, and nothing more, is laid bare, disinfected, and surrounded with aseptic towels. These, after the dressing has been taken away, are arranged all round the field of operation, so that it is impossible for the hands of the surgeon or of his assistant, or any of their instruments, ligatures, or sponges, to touch anything which has not been disinfected and wetted with lotion. A thin mackintosh may be placed beneath the towels to keep the patient's clothing and blankets dry.

For laparotomy the abdomen is sometimes covered with a mackintosh apron with a hole in it to surround the incision. The edges of the hole in the apron are fastened to the skin with soap plaster. I do not use an apron of this kind, because it cannot be sterilised.

When a part which is difficult to disinfect is near the field of operation, it should be covered with a shield of carbolic gauze which has been soaked in biniodide lotion. In operations for the radical cure of hernia, of hydrocele, or varicocele, it is especially important to shut off the organs of generation with such a shield. At times the rectum or other septic orifice has to be excluded by the same device.

An operation founded upon the principles of aseptic surgery is a bacteriological experiment. If our disinfectants and antiseptics were perfect, and surgeons, assistants, and

* "On Asepsis in Current Surgical Practice in Urgent Cases and Country Practice," *The Medical Week*, vol. i, No. 45, p. 536.

nurses infallible, wound infection would never be known. But even now a death from septic infection causes much searching of the heart, and suppuration is a deep reproach.

(*To be continued.*)

So-called Mountain Sickness.

By MALCOLM L. HEPBURN, M.D., B.S., F.R.C.S.

MOST people have heard of mountain sickness, but why and under what circumstances it makes its appearance is perhaps not so well known; and the readers of the JOURNAL will, I hope, find a few disjointed remarks on the subject of some interest.

For some years its very existence was doubted, and even at the present day there are some who say confidently that it never occurs, and rather ridicule those who try to investigate the cause. I am inclined to agree with them as far as the Alps are concerned, but let these individuals go and climb in the Andes or the Himalayas, and I can guarantee that they will return sadder and wiser men.

To begin with, the name is a bad one, since it at once suggests vomiting as the most prominent symptom, when, in reality, it is almost invariably absent; in fact, when this symptom does occur one may generally say with confidence that the climber is not suffering from mountain sickness.

I shall probably be asked the question, What is it, then, if it is not sickness? To judge from the earlier writers, such as Humboldt, Dr. Speer, Dr. Gardner, Dr. Reed, &c., mal de montagne (the better name) is a most complicated disease; but on glancing down their tables of symptoms it is evident that there is a general mixing up of many symptoms which occur on the mountain-side, absolutely regardless of their causation. Of late years it has been more thoroughly investigated, especially by Mr. Whymper in the Andes and by Sir W. M. Conway in the Himalayas, and it is only by studying the accounts given by mountaineers at these heights that one can expect to get a correct description of the symptoms, which are—

1. Accelerated respiration, with now and then spasmodic gulps.
2. Accelerated heart-beat.
3. Intense headache.
4. Slight rise of temperature.
5. Incapability for exertion, with tired feeling in the limbs.

These are the acute symptoms, which pass off in a few days, leaving as chronic—

1. Increased respiration and increased heart-beat.
2. Tired feeling in the limbs, especially on exertion.

N.B.—Notice that there is no mention of bleeding from the nose, &c., as described in earlier accounts.

The above symptoms show themselves usually in every member of the party about the same time at a height of about 16,500 feet, independently of fatigue, unsuitability or insufficiency of food, or an impaired condition of the circulatory, respiratory, or digestive systems. Mr. Whymper suffered from his symptoms quite suddenly after he had ridden up to this height, so that no element of fatigue in the strict sense of the term could have come into his case. (The slight rise of temperature is only mentioned by Mr. Whymper, and is probably an accident.) The great difficulty of the earlier writers appears to be that they did not differentiate between true mountain sickness, fatigue, insufficiency or unsuitability of food, &c., and hence their long list of symptoms which appeared at various heights on the mountain-side, and were never constant.

As regards the causation of the symptoms, many theories have been put forward and many experiments have been done with a view to arriving at a definite conclusion. There are two conditions of the atmosphere at high altitudes which serve as the great foundations upon which to build any theory, viz.:

1 Diminished atmospheric pressure,
2. Deficiency of oxygen per unit volume.

There are other conditions where diminished pressure shows itself or can be produced, viz.—laboratory experiments on persons sitting under bell jars where the air is artificially exhausted, aëronaut experiments, and in the change from the atmosphere of caissons to the ordinary air (producing often what is known as caisson disease). We must, therefore, see what help, if any, we can get by studying the symptoms of those who are subjected to any of these latter conditions, and the most recent writers, especially M. Paul Bert, in his *La Pression barométrique*, have made use of these cases very largely in investigating the cause; but it does not seem to have occurred to one of them that the two states of the atmosphere above described may act more or less separately, and that what is mainly the cause in the one case may not be the cause in the others.

Now the symptoms of caisson disease, of aëronauts, and of those subjected to artificial reduction of pressure, are all very similar, and are as follows:

1. Excruciating pains, generally in knees.
2. Gastric pain and vomiting.
3. Subsequent paralysis, often permanent.
4. Cerebral symptoms, sometimes coma and death.

These are much more severe than the symptoms of mountain sickness, and are experienced under conditions absolutely different from those which mountaineers encounter. To put it roughly:—

(*a*) Aëronauts, &c., experience a very much more rapid reduction of pressure than mountaineers.

(*b*) They remain only a very short time at the reduced pressure.

(*c*) No element of fatigue has to be taken into consideration.

(*d*) The amount of oxygen in the air to which the men are exposed is normal when they suffer from the symptoms of caisson disease.

N.B.—These points are mostly gathered from M. Paul Bert's experiments, and from the descriptions of caisson disease.

If the conditions are so different, what help can the aëronaut experiments, &c., give us? I say absolutely none; and, without entering into the reasons (which would make this paper a great deal too long), I may say that I consider the symptoms of aëronauts, &c., due mainly to the *rapidly* diminished pressure of the atmosphere. An additional piece of evidence in support of this theory is that inhalation of oxygen did not remove the symptoms in M. Paul Bert's experiments, the deficiency of this gas being considered by him to be the chief cause. I do not believe that *gradually* diminished atmospheric pressure would ever produce any symptoms *per se*, since the reason we do not feel the normal atmospheric pressure is because the pressure is equal and opposite in every direction; so that if it were possible to have the pressure *nil*, and yet somehow or other get the oxygen we required and the carbonic acid removed, and provided also the pressure were gradually reduced so as to allow the tissues all over the body time to be so arranged that the pressure might be equal and opposite in every direction, then the body would practically be in the same condition as at the ordinary atmospheric pressure.

I will now mention briefly the various theories on the subject, and it must be understood that those who put forward their views mean them to apply to all forms of reduced pressure.

1. *Mr. Whymper's.*—Mainly reduction of atmospheric pressure, admitting diminution of oxygen per unit volume as a factor (*Great Andes of the Equator*).

2. *M. Paul Bert's.*—Deficiency of oxygen per unit volume.

3. *Mr. Dent's.*—Cerebro-spinal anæmia, especially in the lumbar part of the cord (*Geographical Journal*, Jan., 1893).

4. *Dr. Clifford Allbutt.*—Dilatation of the heart.

5. *Mr. C. G. Monro.*—Four factors:

   (*a*) Deficiency of oxygen;

   (*b*) Cerebro-spinal anæmia (the chief cause);

   (*c*) Dilatation of the heart;

   (*d*) The taking of a meal (*Alpine Journal*, 1893).

6. *Professor Roy* (on Conway's symptoms).—Asphyxia.

To criticise roughly, if Mr. Whymper's theory be correct, how does he explain the sudden occurrence of his symptoms when the reduction of pressure was so gradual? M. Paul Bert's view may be correct as far as mal de montagne is concerned, but he certainly did not prove it to be so in his experiments on persons subjected to artificial reduction of pressure. Mr. Dent's suggestion is rather complicated, and in reading his account I do not think he has sufficient evidence upon which to base it. Dr. Clifford Allbutt's theory involves an impaired condition of an organ in the body which is only an indirect cause of fatigue, this latter giving rise to very similar symptoms, which would occur under any circumstances with excessive exertion, whether at high altitudes or not. Mr. Monro's opinion is practically the same as Mr. Dent's, but two of his factors are merely indirect causes of fatigue. Professor Roy, in his remarks, does not enter fully into particulars, so that his term asphyxia appears rather a strong expression to apply to the cause of the symptoms. Moreover all these writers give too prominent a place to vomiting, which we have seen only rarely occurs.

Now I am inclined to think that the symptoms of mountain sickness can be explained by deficiency of oxygen per unit volume, and I will briefly endeavour to show how this alone can account for everything.

In the physiology of respiration we learn that blood exposed to gradually increasing amounts of oxygen does not absorb much more than on ordinary occasions, and also that when exposed to gradually diminishing quantities of oxygen it does not give off much at first, but that when the amount of oxygen gets to 10 per cent. (*i.e.* 300 mm. pressure, which corresponds to that at a height of about 17,000 feet) the blood suddenly gives up a large quantity of oxygen at once. Surely this sudden evolution of oxygen will account for the equally sudden, and often spasmodic, increase of respiratory movements. The reason why this symptom subsides, and only presents itself on exertion is that the blood is capable of holding and making use of a smaller quantity of oxygen than usual *during rest*, but that the same amount is insufficient during exertion. The intense headache is due to the fact that blood deficient in oxygen, circulating through the centres in the brain, raises the blood-pressure, and in addition the vessels of the brain have a tendency to be over-full, due to the fact that the cold at high altitudes drives the blood from the surface into other parts of the body, and, amongst other places, the brain. The recovery of this symptom is due to the vaso-motor mechanism recovering itself, which it does even when the medulla is mechanically severed from the spinal centres. The tired feeling in the limbs is due to the fact that although the muscles are not dependent upon a supply of oxygen for the manifestation of their energy, yet they cannot maintain their irritability unless a good stream of arterial blood be supplied; hence they become fatigued on the slightest exertion. This is felt more in the lower limbs than elsewhere because they have the most work to do.

There is much more which is well worthy of study in connection with this subject, especially as regards caisson disease and the symptoms of aëronauts, but I will content myself with summing up as follows:

1. The symptoms of mountain sickness (so called) are due to the deficiency of oxygen per unit volume which is present at high altitudes.

2. Mal de montagne cannot be recognised below 16,500 feet.

3. The symptoms experienced by aëronauts, &c., are due mainly to rapidly reduced atmospheric pressure.

Mal de montagne may be guarded against by—

1. Walking very slowly, and taking a long time (often many days) to accomplish the ascent of a high mountain.

2. By having a supply of oxygen, somehow or other, when above a height of 16,500 feet.

By observing these last two rules I believe it is quite possible for the highest mountain in the world to be ascended, provided the weather remains fine for the requisite number of days.

N.B.—I have not entered into the subject of fatigue, which is closely allied to mountain sickness, but on studying Dr. Pavy's paper in the *Lancet* for 1876, on the "Effects of Prolonged Muscular Exertion on the System," it will be seen that the symptoms are exactly similar to those of mal de montagne with the addition of vomiting; and the two can be distinguished from one another by the presence of this latter symptom, and by the fact that fatigue will show itself in isolated members of the party often at a level considerably lower than 16,500 feet.

Vacation Pathology.

FROM all appearance it seems that the School Committee acted wisely and were well advised when they arranged a special post-graduate course in Bacteriological Diagnosis. This is, so far as we know, the first venture of this nature, and the class seems to be successful enough to encourage the committee and Dr. Kanthack, who directs the course, to repeat it from year to year. Qualified men only too easily lose sight of the advances which are made in the clinical laboratory,—we say clinical laboratory because, at our Hospital, the work done by the Pathological Department has pre-eminently a direct bearing on the clinical side of medicine and surgery. Although experimental work is energetically carried out as well, the greatest stress is laid on that portion of pathology which is useful and necessary for complete clinical study. What fruits such work can bear the laboratories of the excellent Johns Hopkins Hospital in Baltimore show us. There is always a drawback about pathology which is dissociated from clinical medicine, and our Hospital is to be congratulated on having realised these matters when it appointed a pathologist to look after the living in addition to the pathologists who look after the dead. A diagnosis in the deadhouse is important and also useful, but obviously the diagnosis *intra vitam* is much more important and useful; the dead can look after their dead. It is almost astonishing how much information may be gained at the bedside from a careful histo-chemical investigation of the blood. People may scoff at the presumption of the pathologist when he ventures to give a prognosis after a mere counting and staining of the leucocytes, but observation—patient observation—has emboldened him to do so.

That clinical pathology does give a keen stimulus to clinical observation and speculation must be acknowledged, and for that reason we are fortunate in possessing a laboratory which is directly under the Hospital Staff. At the present time Dr. Kanthack is giving a short course of lectures and demonstrations to initiate those who are able for a while to tear themselves away from the cares of their practice in the advances made in the bacteriological diagnosis of disease. The class is well attended, more than a dozen men being present, not only old Bart.'s men, but, we are happy to say, men hailing from elsewhere. The course extends over two weeks, and meets on eight afternoons—on Mondays, Tuesdays, Wednesdays, and Fridays, from 2.30 to 5 p.m. Dr. Kanthack begins with a short lecture, illustrated by lantern slides belonging to Dr. Klein's excellent collection. This demonstration is followed by practical work in the laboratory, where Dr. Kanthack is ably assisted by his collaborator, Dr. Drysdale. The work is heavy, but is enjoyed by all, and it is a pleasure to see our small laboratory full of men engaged in serious labour which brings perhaps no other reward than the satisfaction of having done it. We think that occasional post-graduate courses of this nature are to be encouraged, since they remind the past students of the existence of their old Hospital, and convince them of its vitality. That it must be gratifying to our young Pathological Department to find so much support from those who have their examination career behind them goes without saying, especially as it is in the condition of many other institutions which never appear in public without the exasperatingly familiar notice, "Funds urgently needed." It may not be generally known, but we may state it on the best authority, that since the endowment of our pathological laboratory is naturally and necessarily limited, Dr. Kanthack devotes a fair proportion of fees to "running" his department. For this reason, if for no other, we are glad to find the steady increase of workers who flock to our little laboratory, and with still greater pleasure do we anticipate the time when it is found that the space is insufficient: this must happen pretty soon. But how are we to expand? Perhaps some will reply by pointing with Cato-like perseverance to the hatless boys in yellow stockings: "Cæterum censeo scholam istam esse delendam." Be it so.

Notes.

By an oversight in our last issue we omitted to print Mr. F. W. Gale's name amongst those who had taken the diploma of M.R.C.S. and L.R.C.P.

Last winter Mr. Gale expressed his determination not to

sing at any more "Smokers" until he had qualified. Thus every one will be glad to hear the news that Mr. Gale is again "disengaged" for the coming winter.

* * *

TWO BART.'S MEN have been successful in the competition for the Indian Medical Service recently held, viz. Mr. A. W. R. Cochrane, who was second with 2594 marks, and Mr. R. P. Wilson, who was fourth with 2446 marks.

* * *

DR. WEST'S paper on the "Treatment of Diabetes Mellitus by Uranium Nitrate," read at the recent meeting of the British Medical Association, appears to have attracted considerable notice, and deservedly so, for in uranium nitrate we have, according to Dr. West's observations, what is practically a new remedy in the treatment of a complaint for which we have only too few therapeutic agents.

* * *

NO PROGRESS has been made lately in connection with the much-needed reform of the University of London, so as to adapt it into a great teaching university. It will be remembered that a few months ago a bill to give effect to the recommendations of the Royal Commission was introduced into the House of Lords. This bill necessarily lapsed owing to the change of Government and the General Election. What attitude Lord Salisbury's Government will take on the question is not yet clear, but from the statement made recently in the House of Lords by the Duke of Devonshire it seems that the opponents of the scheme are actively at work, and that the minority in Convocation have already made some headway with the leaders in the House of Lords. It therefore behoves those who wish for a *real* University in London to be "up and doing," so that the weight of the opinion of the great leaders of education in London may be properly felt when Parliament meets again.

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DR. LAUDER BRUNTON, F.R.S., has been elected Physician to the Hospital, thus making the full Medical Staff equal to the Surgical.

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DR. HERRINGHAM has been appointed Assistant Physician to the Hospital.

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A VACANCY in the Staff of Assistant Physicians to the Hospital is announced, and the election will take place on September 26th.

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DR. VINCENT HARRIS is now engaged on a book on *The Treatment of Pulmonary Consumption*, which will appear shortly. The publisher is H. K. Lewis.

* * *

WE ARE GLAD to see that some notice is being taken of the question which we raised in our last issue of payment for medical evidence at coroners' inquests where the deceased has died in a Charitable Institution. We hope the matter will be still further taken up, and not allowed to drop until some less unsatisfactory arrangement has been made.

SIR DYCE DUCKWORTH has been appointed to deliver the Lumleian Lectures at the Royal College of Physicians next year.

* * *

MR. M. L. M. VAUDIN, who has been studying at Bart.'s for the past three months, has been successful in the Competition for the Army Medical Service, taking the sixth place with 2213 marks.

* * *

MR. HOWARD MARSH will take the chair at the Old Students' Dinner on October 1st in the Great Hall of the Hospital.

* * *

DR. HENSLEY is acting as Hon. Sec. for the Dinner, and those who wish to attend are requested to communicate with him without delay. The price of the tickets is one guinea.

* * *

IT IS with much regret that we hear of the death of Dr. Bristowe, Consulting Physician to St. Thomas's, and author of the almost classical book *Theory and Practice of Medicine*.

* * *

WE HASTEN to correct an error in the last number, viz. the spelling of the name of the Governor through whose generosity the "shelters" in the Square are being erected. We are indebted to Mr. Ebenezer Homan for this kindness.

* * *

EVERY BART.'S MAN will be glad to hear that Sir James Paget's name has been given to one of our wards. *Charity* is henceforth to be known as *Paget* Ward.

Amalgamated Clubs.

BOXING CLUB.

THE officers of the Boxing Club are as follows:

President.—Mr. H. T. Butlin.

Vice-Presidents.—Mr. W. H. Jessop, Mr. A. N. Weir.

Hon. Secs.—Mr. C. G. Meade, Mr. J. W. Hughes.

Committee.—Mr. T. Martin, Mr. Baker, Mr. Andrew, Mr. Hawkins.

The Club Rooms in Red Lion Passage (three minutes from the Hospital) are open on Mondays, Wednesdays, Thursdays, and Fridays, from 3.30 till 6.30.

Alec Roberts, the Club Instructor, attends on Fridays.

Men who wish to join the Club should (after becoming members of the Amalgamated Clubs) find out either of the Secretaries, who will be glad to pilot them through the tortuosities of Cloth Fair to the Club Room.

RUGBY FOOTBALL CLUB.

The officers for the season 1895–6 are as follows:

President.—Mr. A. A. Bowlby.

Vice-Presidents.—Mr. A. N. Weir, Mr. H. B. Meakin, Mr. S. P. Cornish, Mr. P. W. James.

Captain 1st XV.—Mr. H. Bond.

Captain 2nd XV.—Mr. J. C. S. Dunn.

Hon. Sec. and Vice-Captain.—Mr. H. M. Cruddas.

Assistant Hon. Sec.—Mr. A. J. Wells.

Committee.—Mr. P. O. Andrew, Mr. G. C. Marrack, Mr. F. H. Maturin, Mr. T. W. Nunn, Mr. A. L. Ormerod, Mr. H. Body.

The list of matches which we print below shows a distinct improvement as regards "class"—or rather a return to the class of previous years. We trust that the team may improve as much upon last year as last year's did on the preceding team. Should this happen, we cannot fail to at last adorn the Library table with the Rugby Cup.

LIST OF MATCHES FOR 1895-6.

1st XV.

October	5.—Civil Service	Winchmore Hill.
„	12.—Streatham	Streatham.
„	19.—Ealing	Winchmore Hill.
„	26.—Marlborough Nomads	Surbiton.
„	30.—R.N.C.	Greenwich.
November	2.—Upper Clapton	Clapton.
„	6.—East Sheen	Richmond.
„	9.—R.I.E.C.	Cooper's Hill.
„	20.—Mason College	Birmingham.
„	23.—Wickham Park	Winchmore Hill.
„	30.—Rugby	Rugby.
December	4.—R.C.Science (A.)	Winchmore Hill.
„	7.—Lennox	Dulwich.
„	14.—Portsmouth	Portsmouth.
„	21.—Harlequins	Chiswick.
January	11.—Wickham Park	Lee.
„	18.—London Welsh	Tufnell Park.
„	20.—Leicester	Leicester.
„	25.—Northampton	Northampton.
„	29.—Royal Engineers	Chatham.
February	1.—Upper Clapton	Winchmore Hill.
„	12.—R.C.Science (A.)	Away.
„	15.—Marlborough Nomads	Winchmore Hill.
„	19.—East Sheen	Richmond.
„	22.—R.M.A.	Woolwich.
„	29.—Rosslyn Park	Old Deer Park.
March	7.—Croydon	Croydon.
„	14.—Kensington	Wood Lane.

2nd XV.

October	5.—Civil Service II	Richmond.
„	12.—U. C. School	Willesden Green.
„	26.—U.C.S. Old Boys	Gospel Oak.
November	2.—Upper Clapton II	Winchmore Hill.
„	9.—Amhurst	Clapton.
„	13.—St. Thomas's Hosp. II	Lambeth.
„	16.—Wickham Park II	Winchmore Hill.
„	23.—Mitcham	Mitcham.
„	30.—Guy's Hosp. II	Honor Oak.
December	7.—Marlborough Nomads II	Winchmore Hill.
„	14.—West London	
January	11.—Rosslyn Park II	Winchmore Hill.
„	25.—Croydon II	Winchmore Hill.
„	29.—Merchant Taylors' School	
February	1.—Wickham Park II	Lee.
„	8.—U.C. School	Winchmore Hill.
„	15.—Marlborough Nomads II	Surbiton.
„	22.—Upper Clapton II	Clapton.
„	29.—St. George's Hosp. II	Winchmore Hill.
March	7.—St. Thomas's Hosp. II	

Abernethian Society.

THE opening address of the 101st Session of the Society will be delivered by Dr. Church in the Anatomical Theatre on October 10th at 8 p.m. His subject will be "The Rise of Physiology in England and its Effect on the Practice of Medicine." Freshmen are specially invited to attend. Tea and coffee will be served in the Library after the Address.

An Up-to-Date Toxic Lament.

DIPHTHERIA BACILLUS *loq.*:

ALAS that I, who am so small,
Who singly do no harm at all,
Who have a name so great and "tall,"
Should live to see death's sentence fall
On the wily Klebs-Löffler Bacillus!

All uncontrolled we had the run
Of every tender little one.
The throat we loved; when that was done,
Nose, lungs, and larynx, one by one,
With nourishment managed to fill us.

But now, no sooner have we found
A pleasantly juicy feeding ground,
Than something happens,* and we're bound
To loose our hold without a sound,
For that child has managed to "spill" us.

We've grown in serum and on plates,
On broth, in tubes, we've met our mates;
Klein used small kittens as our baits:
But all is over! for the Fates
So cruelly seek now to kill us.

Ah! doctor, hear my sad lament!
I can't keep straight, my ends are bent!
For, as you're one and all intent
On killing us, where is the vent
Of escape for any Bacillus?

DOCTOR *loq.*:

Ah! sweet though small aërobic one,
Your days of luxury are gone,
No more unbridled will you run,
Your membranous and croupy fun
Is past, for you're doomed, dear Bacillus.

A little antitoxine, please,
I think will put you at your ease,
Your little corpse it now will seize,
And, may be, somewhat raise my fees!
Farewell, Sir Klebs-Löffler Bacillus!

N. O. WILSON.

The St. Bartholomew's Hospital Amateur Dramatic Club: a Retrospect and a Forecast.

THE forthcoming 12th Anniversary of the birth of the above Club affords a fitting opportunity for saying a few words about an institution which is perhaps less known than any other students' club in the Hospital.

It was in the Winter Session of 1882 that a few members of the Junior Staff and Mr. Townesend, then only a dresser, approached the Staff for permission to give a short dramatic sketch at the approaching Christmas Concert. The permission having been obtained, it was decided after much discussion to give "A Regular Fix" and "Little Toddlekins," two well-known farces. Those who know the time and trouble involved even now in giving an entertainment on our well-appointed stage, aided by our experienced army of carpenters, scene-shifters, lampmen, gasmen, and firemen, can perhaps realise the difficulties met with by our predecessors, the pioneers of the Dramatic Club. Their stage had an opening only 16 feet wide and 7 feet 6 inches in height, there was no gas laid on, and footlights were represented by a row of candles, whereas side and top lights were conspicuous by their absence. Those who are familiar with the noble proportions of our Great Hall can imagine the insignificant effect of such a construction as this. In addition to this they had to deal with a set of carpenters who, however willing, were quite inexperienced in stage work, and

* Injection of antitoxine.

with scene-shifters whose only object was to save themselves trouble, and who, small as the stage was, would only bring down enough scenery to fill half the available stage room. However, notwithstanding all these drawbacks, the little company worked with a will, and the verdict when all was over was "complete success." Encouraged by the result of their efforts, those who were keenest on the Thespian art determined to form themselves into a club, and accordingly on October 12th, 1883, the first meeting of the St. Bart.'s A. D. C. took place in Mr. Cross's house. The first act of the new body was a happy and a far-seeing one, namely, the election of Mr. Cross as President; and since that time we have owed more to the kind offices of that gentleman than we can ever hope to repay. The original members of the Club were Mr. Townesend (the founder), Messrs. Berry, Oscar Clarke, Owen Lankester, Howe, Gill, Colville, and Wigmore. Dr. Oswald Brown was stage manager, and Mr. Gill secretary and treasurer. The plays for this year (1884) were "He's a Lunatic," and Act 2 of "The Critic." The stage was much improved, being deepened and widened, and gas was laid on; but still, owing to inexperience, the actors suffered much at the hands of the scene-shifters, who were utterly uncontrolled. The success of this entertainment put the Club on a firm footing in the Hospital, and a dramatic portion of the Christmas Entertainment was now looked upon as a regular thing. In January, 1884, a series of dramatic readings were started by the Club, and several of the classics were read; however, these were not so popular as their proposers could have wished, and they were finally abandoned, giving way, at the suggestion of Mr. F. C. Wallis, to entertainments for the Nursing Staff, still held at intervals during the Winter Session.

The following year Dr. Oswald Brown resigned, and Mr. Stephen Townesend was elected stage manager, an office which he held for five years. The following were the plays produced under his management:—"The Secret Agent," "The Post of Honour," "A Regular Fix," "The Turned Head," and "Comfortable Lodgings." But it was not till the winter of 1888 that the Club felt strong enough to soar above the region of farces, and endeavour to do something worthy of its then members. It was in a better position financially and histrionically than it had ever been before, or has ever been since. It had then the services of Messrs. Townesend, Valerie, Wigmore, Evill, Brownlow, Hall, and Knight, so it was decided to attempt "David Garrick," a risky venture for an amateur dramatic club with only men available to play female parts; and, indeed, this decision caused a storm among many of the members of the Club, who prophesied a dead failure, and endeavoured to prejudice the minds of those outside the Club by enlarging on every little hitch that occurred at rehearsals. However, the managers had put their hands to the plough, and were determined to carry the thing to a triumphant issue in spite of the cavillers. No play has had so much care expended on it. Special scenery was painted, special properties and dresses made, and on January 10th, 1888, it was produced. It will for ever remain the greatest success the Club has ever produced. Next year was also remarkable for being the least successful of the Club's efforts. The play was "The Heir at Law." It was an unhappy choice; it is quite uninteresting and unsuited to amateurs. It was also unfortunate, as it was the only occasion on which ladies were allowed to act, and the ladies who were to have performed got ill shortly before the date of the play, and their places had to be filled by understudies who were lacking in experience. Mr. J. Valerie was stage manager. In 1890 the programme consisted of the trial scene from "The Merchant of Venice," with Mr. Townesend as Shylock, and Act 2 of "The Critic." Mr. Townesend was again stage manager.

In the following years Mr. C. W. Emlyn was stage manager. The plays were "Vice Versâ," "Tom Cobb," "Engaged," and "Not such a Fool as he looks," all of which were successful, and too recent to need further mention here. In 1891 a performance of "On Guard," by W. S. Gilbert, was given at St. George's Hall in aid of the Royal Free Hospital, which resulted in a balance of £50, and in 1893, at the same place, a performance of Albery's "Two Roses," in aid of our Samaritan Fund, whereby we made £70. Last year the play chosen was Byron's "Old Soldiers," and, though somewhat unsuitable, may be reckoned among the Club's successes. So much for the past; now as to the future of the Club.

This depends on three chief factors:—1. New members. 2. The admission of ladies to take part in the entertainment. 3. The admission of all students to the Annual Entertainment.

For the first, a club such as the Bart.'s A. D. C. differs from other dramatic clubs, inasmuch as its ranks are continually changing. Men come up to the Hospital for five or six years, and then go away qualified or otherwise, and no more is heard of them, so that one year we may have a fairly strong cast, and next year have scarcely a man in the Club who can play a part decently. Consequently the Club is always ready to receive with open arms men who can act, or who think they would like to try. Moreover it is always advisable for a man to join as early in his Hospital career as possible, so that if he turns out to be a useful member the Club may have the advantage of his services as long as possible. It has been said that even if men do join they find a difficulty in getting parts allotted to them. Never was a greater mistake; any member who wants a part can have one by simply asking for it. The system employed is this:—A short time before the choice of a play an announcement is made by the Acting Manager to the effect that a play will be chosen and cast by a certain date, men wanting parts to write in for them. When this has been done a play is chosen suitable to the number and capabilities of the men who wish to act. To test new members, parts

are first of all given to them in nurses' entertainments, and their future position in the Club depends in some measure on the manner in which they acquit themselves therein.

With regard to the admission of ladies to take part in the Hospital entertainment, it must be said that till this permission is granted our annual performance will never be on a higher level than mere buffoonery. To ask educated professional men to take part in a performance where a great strapping youth of six feet or over is mimicking the airs and graces of a girl is, in our opinion, the greatest insult that can be offered to them. If such a thing occurred on a London stage it would be classed as not only grossly vulgar, but also exceedingly indelicate; and yet educated men and women come to see gentlemen good-naturedly make tomfools of themselves for their amusement. This restriction on the part of the Hospital authorities is not only an insult to us and to our friends whom we should ask to act, but also to the more refined portion of our audience.

The third factor in the future of the Club is that it should be more widely known among the students. Very few men of the first and second years know anything about it; and, even if they do see the notice-boards in the lobby of the school and smoking-room, never hear anything of the Club's proceedings, and it is only those third year's men who happen to be clerking or dressing in the wards at Christmas that get invited to the entertainment. This is not as it should be; every student ought to get tickets, he has as much right there as the patients. It has been said that there is not room for them in the Hall. Very well, then let a separate night be set apart for students and their friends, and let the other two nights be kept for the Governors and Staff as heretofore. When this request was made before it was met by the flimsiest of excuses, viz. that the patients would be disturbed by hearing carriages in the square on a third night. Surely if it were injurious on a third night it would be infinitely less so than on a first and second, as they would be more used to it. Another excuse was that the beadles got tired of seeing the performance after the second night. Our experience is that the more entertainments there are, the better the beadles are pleased. However, this remains between the students and the office; if the students want a night devoted to themselves, we have no doubt that if they petition that august body it will consent to waive its objections, which do not seem very weighty.

Appointments.

MR. T. W. H. GARSTANG, M.R.C.S.Eng., L.S.A., has been appointed Medical Officer of Health to the newly formed Knutsford Urban District Council (Cheshire).

* * *

MR. R. G. HOGARTH, M.R.C.S., L.R.C.P., has been appointed Senior Resident Medical Officer to the General Hospital, Nottingham.

* * *

MR. C. P. CROUCH, M.B.Lond., F.R.C.S., has been appointed Honorary Surgeon to the Weston-super-Mare Hospital.

Examinations.

H. S. MAW has passed the final L.S.A. in Surgery, Medicine, Forensic Medicine, and Midwifery.

* * *

A. H. WADE has passed the final L.S.A. in Medicine and Forensic Medicine.

* * *

G. LOWSLEY has passed the final L.S.A. in Medicine.

* * *

M. GEPP has taken the D.P.H. of the Royal College of Physicians and Surgeons.

The Appointment of a Fifth Physician.

FOR the information of students and the interest of old Bart.'s men we give the official re-allotment of medical and surgical beds which takes effect in October.

ALLOTMENT OF MEDICAL AND SURGICAL BEDS AFTER ELECTION OF FIFTH PHYSICIAN.

	Male.		*Female.*	
Dr. Church	Mark	28	Faith	22
Dr. Gee	Luke	28	Hope	22
Sir D. Duckworth	Matthew	28	John	21
Dr. Hensley	Colston	24	Mary	22
Dr. Brunton	Rahere	24	Elizabeth (back)	14
Dr. Champneys			Martha	20
			Elizabeth (front)	14
Mr. Smith	Harley (front)	13	Lawrence	30
	Henry	26		
Mr. Willett	Harley (back)	13	President	31
	Pitcairn	26		
Mr. Langton	Kenton	26	Lucas	26
	Charity (front)	11		
Mr. Marsh	Darker	25	Stanley	29
	Abernethy	18		
Mr. Butlin	Sitwell	25	Paget	22
	Charity (back)	11		
Mr. Cumberbatch	Abernethy	2	Stanley	2
Mr. Vernon Mr. Jessop	Albert Edward	13	Alexandra	12

Besides Erysipelas, 20; Diphtheria, 8; Unassigned—Casualty, 15; Isolation, 3.

Correspondence.

To the Editor of St. Bartholomew's Hospital Journal.

ESPRIT DE CORPS.

SIR,—After "mens sana in corpore sano," the most frequent quotation one hears in hospital speeches, especially after dinner, is "esprit de corps." In scientific circles "audi alteram partem" is also frequently inculcated, and differs from the others perhaps in being more frequently performed. But from whatever cause, whether because post-prandial, from indifference, inability, insincerity, or non-necessity, the "other side" of the "mens sana" and "esprit de corps" injunctions is *not* heard. Now the injunctions of "mens sana" are only followed for our own obvious advantage, not from any duty; and this it is that makes the "Grace Testimonial" so supremely ridiculous. It is, however, of "esprit de corps" that I write. We all know *one* side. It is said, sir, we *must* attend hospital dinners, however bad, and concerts, however second-rate; *must* play if required, *must* turn out to the various matches even of the last new club. How lacking, forsooth, in "esprit de corps" was the junior staff not to attend the Decennial Club dinner! One taking this view would point out most of that staff are Cambridge men, who notoriously rarely busy themselves in hospital matters. The point is, are they wrong? Theoretically I think not wrong, actually I am inclined to think "esprit de corps" is a necessity and is right. Why, then, theoretically are they not wrong (and proof of not wrong is by no means a proof of right)? The "necessity" of "esprit de corps" is, I maintain, a logical fallacy, and classible under Stuart Mill's *a priori* fallacies. It is put down as a proposition which may be received without proof, as an axiom or self-evident truth. But it is an axiom which has not been through the fire; it is classed as one of those ultimate premises which are facts of our subjective consciousness, and ranked amongst ideas, sensations, emotions, &c. It has no right amongst such essentials. We enter the hospital and pay our fees—high to many of us, and we try to do our best for ourselves and parents—nearly the essential law of biology. Those who do not,

either do not from folly or mistake, because the "esprit de corps" preachers act (i) from some notion of self-advantage; or (2) from ability, *i. e.* after attaining their aims have sufficient time and opportunity to afford it. These last will act (i) from pleasure; (ii) for self-advantage. Consequently two elements are at work, actual pleasure or necessity, and may result from folly, mistake (or miscalculation), or egoistic advantage. But to those who act from pleasure it is pleasant, and deserving of no great praise from others; those acting from folly or mistake pity, and the egoists do not merit indignation. Would one expect "esprit de corps" on the Stock Exchange or Corn Market? Just as *they* are busy money-making, and are there of necessity, so are *we* in hospital for our own advantage. *All* of course are likely to reverence and take an interest in walls resounding with the din of gain. This, then, is the opposite side of the question, and I would sum up and conclude thuswise. The point is why; and the why is as little satisfactory here as anywhere. Philosophy and metaphysics are sophistic, and knowledge is finite, and the answer is to be found in an appeal to intuition, and seek what causes the most happiness. The sole duty of man, I maintain, is happiness; and, as a rule, happiness will be found in duty. Some will *not* have this intuition, their protoplasm is not so constructed; no blame then to them. Others *will* have it; no praise then to them. The characteristic of personal protoplasm or intuition is not for praise or blame. Schopenhauer has it somewhere, "To become indignant at their conduct is as foolish as to be angry with a stone because it rolls into your path." I would corollarise—to be pleased at their conduct is as foolish as to be delighted with an angel because one meets your gaze. I am inclined to uphold "esprit de corps," then, for the following reasons, but it is a purely personal opinion and intuitive:—(1) Because the proof that *absence* of "esprit de corps" is *not wrong* is not possible. (2) With *me* the intuition of its *right* is present, but I deny this intuition to be a necessity and present in all. (3) In an appeal to the object of our existence, happiness will be found to be the object, *and with well-developed minds happiness usually finds a place in "esprit de corps."* With these restrictions let us have "esprit de corps."—I am, dear sir, yours faithfully,

NEO-PESSIMIST.

To the Editor of St. Bartholomew's Hospital Journal.

SIR,—Having read with much interest the article on "Coroners' inquests" in this month's ST. BARTHOLOMEW'S HOSPITAL JOURNAL, I beg, on behalf of the resident medical officers of this Hospital, to express our entire sympathy with the views you put forward, and our willingness to assist you in placing this important matter before a higher court.—Believe me, yours truly,

E. F. CURREY,
Senior House Physician,
West London Hospital, Hammersmith, W.

August 20th, 1895.

To the Editor of St. Bartholomew's Hospital Journal.

SIR,—In an interesting paper on "Biblical Materia Medica" in the August number of this JOURNAL Dr. Maidlow mentions the drink which was offered to Christ before His crucifixion. Some commentators consider that this was a solution of some narcotic in the thin wine which formed the common drink of the soldiers, and which being usually sour might be called indifferently by the name either of wine or vinegar. The word myrrh is considered to be used in a general sense, like the word gall, as meaning some resinous or gummy substance. The term "gum opium" used to be frequently used in this country, and possibly opium may have been the narcotic actually employed. It is evident that Christ's refusal to drink the mixture was on account of the resin or gum it contained, for a little later He is described both by St. Matthew and St. Mark as drinking vinegar from a sponge. The bitter waters of Marah were probably not rendered sweet by the introduction into them of any berries, of which the quantity required to meet the needs of all Israel would have been enormous, but by a simple device which is described by Josephus. The water of Moses' wells near Suez at the present day is slightly brackish, but the quantity of salt it contains is not sufficient to render it at all unpotable. If exposed to the sun, however, the water evaporates, or the proportion of salt in the residue becomes greater and greater until it is absolutely unfit to drink. Josephus states that when Moses came to the pools of Marah he set the stronger members of the congregation to bale out the water, which was so charged with salt as to be undrinkable, and having split a tree he pushed it down into the sand. Through the rude artesian well thus made fresh water rushed up, and the people's thirst was quenched. The whole confusion in the Authorised Version is due to the original Hebrew word having been translated by the word "cast" instead of "put." The word cast conveys the idea that the tree was thrown haphazard into the water, whereas it was in reality "put" into the pools in a definite manner and with a definite object. It is almost impossible for anyone who has been over the ground where the occurrence is thought to have taken place to imagine the sweetening of the waters in the way suggested by the text in the Authorised Version, whereas one can readily see that the remedy which, according to Josephus, was employed by Moses would be, in fact, the only remedy practicable, and would be as serviceable to-day as it was of old.—I am, Sir, faithfully yours,

ONE INTERESTED IN THE SUBJECT.

To the Editor of St. Bartholomew's Hospital Journal.

A CORRECTION.

SIR,—In the quotation at the end of my speech at the Decennial Club dinner, which you do me the honour to publish, there is, from the printer's error, a word which makes its line mere nonsense, and quite spoils the beautiful verse. The verse, which is from Longfellow's 'Waif,' *should* read—

"And the night shall be filled with music,
And the cares that infest the day
Shall fold their tents *like* the Arabs (not *to* the Arabs),
And as silently steal away."

When a first year's student I heard Mr. Marsh quote the last two lines as appropriate to the fleeting nature of anatomical knowledge.—I am, Sir, yours faithfully,

W. H. MAIDLOW.

Taunton.

To the Editor of St. Bartholomew's Hospital Journal.

SIR,—It has just come to my knowledge that a person giving an address in Goswell Road, E.C., and writing under the name of Dr. G. R. Saunders, has put himself in communication with old Bart.'s men, and stating that he has just returned from New Zealand in distress, and asking for pecuniary assistance. I am happy to state that my brother, Dr. G. R. Saunders, is now in New Zealand, and that such an intimation is entirely untrue. I shall be glad to hear from any of the victims of this person.—I am, Sir, your obedient servant,

FREDERICK W. SAUNDERS, M.B.Cantab.

August 20th, 1895.

Births.

ARMSTEAD.—July 30th, at Chepstow Villas, W., the wife of H. W. Armstead, M.D., of a daughter.

BURD.—August 19th, at Castle House, Shrewsbury, the wife of E. L. Burd, M.D., of a son.

CUTTING.—August 11th, at Chetwynd House, Stalham, the wife of E. B. Cutting, of a son.

GODSON.—August 12th, at Westgate-on-Sea, the wife of Clement Godson, M.D., C.M.Aber., of a son.

HARPER.—August 4th, at Rosary Gardens, South Kensington, the wife of J. Harper, M.D., of a daughter.

LONG.—Sept. 9th, at Greenodd, Ulverston, Lancashire, the wife of Frank T. Long, M.R.C.S., L.R.C.P., of a son.

LEWIS.—July 30th, at Hamilton Terrace, N.W., the wife of E. J. Lewis, M.B., F.R.C.S., of a daughter.

ORMEROD.—August 17th, at Devonshire Terrace, Hyde Park, the wife of C. E. Ormerod, M.D., of a son.

PARTRIDGE.—August 10th, at Camberwell, the wife of W. T. Partridge, M.R.C.S., L.R.C.P., of a son.

Marriages.

BUTLER—SMITH.—On the 5th inst., at St. Mark's, Surbiton, by the Venerable Archdeacon Burney, assisted by the Rev. R. H. Pring, Charles, youngest son of the late William Eldridge Butler, late of Le Court, Hants, to Alice Barbara, youngest daughter of the late John George Smith, of Hill House, Surbiton.

CAMPBELL—GRIBBON.—On August 1st, at St. Matthew's Church, Bayswater, by the Rev. J. A. Chapman, B.A., E. Kenneth Campbell, M.B., F.R.C.S., son of Hugh Campbell, of Wimpole Street, W., and late of Eweland Hall, Essex, to Rose Maude, daughter of the late Brigade-Surgeon G. C. Gribbon (K. O. Scottish Borderers), and granddaughter of the late Sir Hugh Allan, of Montreal, Canada.

Death.

HARRIS.—August 5th, at Dulwich, Ruth Elwin, only daughter of H. E. and Edith Harris, aged 1 year and 9 months.

ACKNOWLEDGMENTS.—*Guy's Hospital Gazette, St. Thomas's Hospital Gazette, St. George's Hospital Gazette.*

JUL 23 1921